## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Lake Shore Obstetrics & Gynecology, LLC (the "Practice") creates and maintains health records describing my health history. I understand that the Practice may use this information as:

1. a basis for planning my care and treatment;

2. a means of communication among many health professionals who contribute to my care;

3. a means by which third-party payors can verify that services billed were actually provided; and

4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to the Practice's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the Practice. In addition, I acknowledge that I received on the date indicated below a copy of the Practice's Notice of Privacy Practices, which describes the obligations of the Practice regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the Practice reserves the right to change its notice and practices. If the Practice changes the notice, I can obtain a revised copy by asking the Manager of the Practice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the Practice is not required to agree to the restrictions requested. If the Practice does agree to such restrictions, however, the Practice must comply with such restrictions.

_____ I request the following restrictions to the use or disclosure of my health information.

_____

_____

Effective Date of Notice:_____

_____ Date:_____
Signature of patient or patient's representative
Printed name of patient's representative:_____
Relationship to patient:_____